EDITORIALS

The Accreditation of Continuing Medical Education

THE SUDDEN AND DECISIVE ACTION of the AMA House of Delegates in July, which then and there terminated the participation of the American Medical Association in the Liaison Committee on Continuing Medical Education (LCCME), has added new confusion to a situation that was already pretty confused. Are there now to be two national accrediting bodies for continuing medical education? The AMA's Immediate Past President, Tom E. Nesbitt, told the House "It's time to bring CME back into the fold of the AMA, where it belongs." This may be true. Accreditation of CME had been the province of the AMA for a decade until 1977 when by agreement among all concerned this responsibility was transferred to the LCCME, which was sponsored jointly by the American Medical Association, the Association of American Medical Colleges, the American Board of Medical Specialties, the Council of Medical Specialty Societies, the American Hospital Association, the Association for Hospital Medical Education and the Federation of State Medical Boards. It is noteworthy that each of these organizations was recognized as having a legitimate interest in the accreditation of continuing medical education programs for practicing physicians. However, in reality the AMA provided the largest portion of the staffing and financial support for the LCCME.

Difficulties to which this writer is not privy must have arisen. It is widely known that there were disagreements between the LCCME and the state medical associations, many of which had been recognized in regard to CME by their state licensing boards. And there may have been some intransigence. But now it is possible that the AMA's accreditation of CME may be recognized only by itself and its component state medical associations, unless it can find ways to take into account the legitimate interests of some of the other organizations. This would certainly be divisive for medicine at a time when we can ill afford division.

But what is really at stake in all of this is the need to provide some real accountability for the quality of continuing medical education programs for the practicing physicians who may wish to participate in a course or program, and for the public which wishes some assurance that a physician's continuing education is meaningful and relevant to the needs of practice. The parties at interest to all this are not only the practicing physicians and the public (including government), but the educators in medical schools, specialty societies and specialty boards, and the hospital providers of CME as well as various other physicians' organizations. Much time and effort has been spent by many of these groups (including the AMA) seeking to improve and assure the quality of CME programs. Most agree that a national accrediting body in the private sector is desirable, and that while the accrediting authority may have to be delegated, this should be within broad guidelines agreed upon by the parties at interest and formalized by the national accrediting body.

Continuing medical education has grown up and matured considerably in the last three years. There are many new forces at work which were not so evident even in 1977. The AMA Council on Medical Education has now been given a large task, a task acquired by fiat, rather than by consensus or agreement. Wisdom, skill and statesmanship will all be required in good measure.

—MSMW

New Perspectives in the Treatment of Hypertensive Patients

JUST WHEN YOU THINK you have learned more about a subject than you really care to know, someone teaches you something new and different. The paper "Nontraditional Problems of Anti-

hypertensive Management" by Peter Rudd and Keith Marton, which appears elsewhere in this issue, offers a fascinating new approach to hypertension. When I saw the title I had that sinking feeling, "Oh no, not another preachy bit about hypertension." But I plowed into it and soon found myself intrigued. This paper could be subtitled "All the *other* things you have thought about hypertension, but never found in one place."

The authors have attacked hypertension from an offbeat angle—its social and psychological effects on patients and physicians—and by the last page you are thoroughly depressed about the whole matter. The discussion is divided into sections on patient screening, disease labeling, diagnosis confirmation, patient compliance and physician adherence.

The section on patient screening describes the poor results from screening operations that occur in most communitywide efforts; few original cases are uncovered with this method. Most of those who come for testing are persons who already have been told they have hypertension or have a family history of the disease; some *cases* turn out to be noncases of labile hypertension (52 percent). The authors cite several reasons: arbitrary limits of abnormality are either too sensitive (false positive) or too insensitive (false negative), or blood pressure variations may be due to equipment or observer problems. Finally, there is the discouraging problem of loss of those truly hypertensive patients who fall between the cracks on follow-up.

"Disease labeling" discusses the serious problems faced by persons who are labeled as "hypertensive." A fascinating fact emerges: asymptomatic patients (previously ignorant of the fact that they have hypertension) suffer a three-fold increase in absenteeism *after* they are told—according to one study. This is 1½ times greater than for those who were previously aware that they had hypertension. Curiously, absenteeism was lowest among untreated, previously aware persons. The rise in absenteeism was associated with treatment, noncompliance and vigorous educational efforts; it was not related to blood pressure control. It is noted that possible causes for this behavior are a lowered "self-concept" and deterioration of marital and home satisfaction. Such patients were observed to consider themselves "more fragile and debilitated." The authors caution that these findings are from a single study and that studies should be done among other types of workers in other environments.

Every clinician who has dealt with hypertensive patients is familiar with this psychologic phenomenon. It occurs in other diseases that are asymptomatic in their early phase, but which have serious long-term sequelae unless effective treatment is instituted and sustained. In the situation of asymptomatic hypertension, we typically have a person who has considered himself healthy. Suddenly, perhaps as the result of a routine physical examination, he is "educated" about his disease: a life-threatening condition that can cause a heart attack or stroke unless he remains on treatment the rest of his life. And to compound the problem, the treatment often causes unpleasant symptoms.

It is difficult to conceive of a more disturbing situation. It demands effective, sympathetic discussion by the clinician to persuade the patient intellectually *and* emotionally about the importance of sustaining the treatment. Yet the clinician must not alarm him and create an emotional cripple. It is not an easy task, and the psychological trauma plus the poor compliance that abounds with this disorder, indicate that physicians are not doing this job well.

Rudd and Marton continue their depressing presentation by describing the increased life insurance premiums for patients labeled hypertensive, which only reinforce the sense of alarm and loss of self-image.

The authors cite the critical need to ensure that the patient does, indeed, have significant, nonlabile hypertension. They state that, despite the Framingham study which correlated *systolic* pressure elevations with congestive heart failure, coronary artery disease, cerebrovascular accidents and electrocardiographic changes, tradition dictates that we treat the diastolic pressure. (Most clinicians have tended to ignore all but the most extreme levels of systolic blood pressure in older folks because of the disabling effect of drug-induced hypotension.) The authors discuss the problems of variations in technique that cause difficulty in establishing the diagnosis: wrong-sized cuff, confusion over whether to listen to phase 4 or phase 5 Karotkoff sounds, observed variation and lack of proper manometric calibration (especially the volatile aneroids). All tend to cause more false-positive observations than false negatives.

As anticipated, the authors reopened the Melby (comprehensive initial workup for all hypertensive persons) versus the Gifford and Finnerty (treat them all, and if there is no response, or if they fall into a special category, *then* do the extensive

workup) controversy. Rudd and Marton favor the latter approach, citing the rarity of curable hypertension and frequent failures after surgical manipulation of renovascular hypertension. I share their view: costs of universal extensive diagnostic workup are prohibitive in this era of cost accountability. *Correctable* diagnosis can be suspected by careful clinical evaluation and minimal laboratory examination.

A detailed and enlightened discussion of the critical problem of *patient compliance* is a high point. In my experience there is no substitute for a zealous nurse with a hot telephone to tweak those hypertensive patients who miss appointments. They must be hounded to discover whether they have become ill, whether the medication is causing embarrassing or otherwise undesirable adverse side effects or whether they are simply too embarrassed to come in because they have failed to take the medication. Compliance is a function of physician perseverance and determination.

As stated earlier, patients must be intellectually and emotionally convinced to continue life-long therapy, yet they cannot be alarmed into disability. The authors also make the key point that therapeutic programs must be kept as simple as possible and tailored to the life-style of the patient. All clinicians have found it valuable to have blood pressures taken at home by reliable family members who are involved with the patient personally and who are convinced of the importance of sustained treatment.

The final section of the paper, on professional variability, presents an incredible array of physician *malfunctions*. These range from poor (or absent) record keeping, failure to recognize hypertension, casual attitude about patient education and failure to pursue those patients who are not cooperative.

The problem of educating physicians about hypertension is real. There is a certain apathy among clinicians about diseases that have few obvious symptoms yet which cause damage at a subtle, nondramatic pace (until the patient gets a myocardial infarction or suffers a stroke). It is an especially unappealing situation when an asymptomatic patient is obliged to take medication that may make him unhappy or even sick. It is a no win situation in the short haul; but in hypertension it is the long haul that is important.

After this doleful recitation the authors nibble at the solution to the problems in two concluding paragraphs. Once again they cite the importance of physician education as the chief factor in solving this multitude of nontraditional pitfalls.

It is a thoroughly readable paper, and it is referenced with a vengeance.

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A New Kind of Melting Pot

SUMMER IS A TIME for reflection and even some dreaming. The slackened pace, if one is lucky enough to have it slacken, provides an occasional moment when one can stand back and look at the forest made up of all the trees that come to one's attention in the course of daily events. For example, if one stands back, reflects and dreams, one might sense that America may be creating a new kind of melting pot, with a new place in the world—with new responsibilities and opportunities for medicine.

America has long been described as a melting pot. For years it was able to absorb and integrate wave after wave of immigrants, primarily from Europe. Most of these entered the country legally and earned their place in American society by working long and hard, as indeed did the earlier settlers who developed the principles of freedom, enterprise and law which served to make the nation great—in fact the envy of the world. Our industrial products were the mark of a new standard of living among even the more advanced nations, and American efficiency was what made this production possible on such a scale. Even today our know-how and expertise are courted by other nations, including the USSR and the People's Republic of China as these nations seek to improve the standard of living of their peoples. The American dollar was pegged to gold and the expression *sound as a dollar* meant something more than it does today.

But this kind of a melting pot seems to have passed its zenith and to be approaching some kind of nadir if one uses only the above criteria. Illegal aliens abound, particularly in the West and parts of the South. Many of these people work hard but do not pay taxes, and many require support through our public programs. Illegal entry of persons and contraband seems to occur almost as if the borders did not exist. Persons of Mexican birth or ancestry will soon be a